West Carleton

Family Health Team

PERSONAL CARE ASSISTANT ENROLMENT FORM AND AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

This form is to be used for the purpose of authorizing someone other than yourself, to communicate with our staff, with regard to your medical information. ***(See reverse side for instructions.)***

1. Primary Patient, *COMPLETE IN FULL 16 years of age and older.*

Name - Last, First, MI			
Street Address			**City**
Province	**Postal Code**	**Telephone #'s (xxx) xxx-xxxx**	
Date of Birth mm/dd/yyyy		**Ontario Health Card Number**	

2. The person listed below is my designated Personal Care Assistant and is authorized to access my medical information.

Name - Last, First, MI			
Street Address			**City**
Province	**Postal Code**	**Telephone #'s (xxx) xxx-xxxx**	
Date of Birth mm/dd/yyyy		**Ontario Health Card Number**	

Relationship: ☐ Spouse/Partner ☐ Blood Relative _____ ☐ Guardian ☐ Power of Attorney ☐ Other _____

3. INFORMATION TO BE RELEASED BY PATIENT TO PERSON CARE ASSISTANT IDENTIFIED ABOVE:

☐ Telephone/verbal communication (all subjects)

☐ All subjects except for the following: _____

☐ Permission to attend all medical appointments with me and to act in the role of Personal Care Assistant in order to help me manage my medical condition.

A separate request (completed documentation release form) will be required for a copy of medical documentation. A copy fee may apply.

4. This authorization will remain in effect until revoked by you.
If you wish to limit the duration of this authorization, please specify the end date below:

☐ End Date: _____

5. I authorize release of my medical information in accordance with the specification listed above.
A photocopy of this consent shall be valid as the original.

6. Signature of Patient _____ **Date** _____

7. I agree to act in the role of Personal Care Assistant. A photocopy of this consent shall be valid as the original.

8. Signature of Personal Care Assistant _____ **Date** _____

WEST CARLETON
family health centre
keeping our community healthy

• Dr. Barry Bruce • Dr. Ewa Ciechanska • Dr. Jeanette Dionne • Dr. Karen Ferguson
• Dr. Mark Fraser • Dr. Michelle Lawler • Dr. Kathy McBride • Dr. Lisa Rosenkrantz
• Dr. R Stecher • Dr. Kristen Tonon • Dr. Eugene Vigneron
119 Langstaff Drive, P.O. Box 218, Carp, ON K0A 1L0
Tel: 613.839.3271 • **Fax**: 613.839.3273 • www.wcfht.ca

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Privacy regulations require your health care team not divulge any information to unauthorized persons. In today's world, it is common for a spouse or partner to arrange appointments for their family members, to check if they should come back for a follow-up, etc. It is permissible for a parent or legal guardian to manage these tasks for a minor. But not permissible for a spouse to act on your behalf unless authorized. We required **written consent** to be on file.

Children that are 16 years of age or older must also grant authorization to a parent or guardian.

By default, a parent or guardian is assumed to have authorization for a minor. It becomes difficult to manage this if the surnames of any of the parents are different than the minors, reside at a different residence or there is rules regarding custody. In these cases please supply full details in writing.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that have already been made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:

West Carleton Family Health Team, 119 Langstaff Dr., Carp, ON, K0A 1L0

Signatures. Generally, if you are 16 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. A spouse can not authorize disclosure of medical information for you unless they have legal rights to do so.

PLEASE DROP OFF, FAX , SCAN AND EMAIL, OR MAIL VIA CANADA POST THE COMPLETED FORM TO OUR OFFICE. THE SIGNED FORM WILL BE ADDED TO YOUR MEDICAL RECORDS.

Mail to: West Carleton Family Health Team, Box 218, 119 Langstaff Dr. Carp, ON, K0A 1L0

Fax: 613-839-3273 Email: reception@wcfht.ca